EAST SIDE CHIROPRACTIC

"Live Healthy, Be Happy"

8228 Biscayne Blvd. Miami, FL 33138
T: 305-403-2595 | F: 305-403-1022

First Name ____________ Middle ____________ Last Name ____________ Nickname ____________

Address ____________ Apt# ______ City ____________ State ______ Zip Code ______

Cell Number (___)________ Home Number (___)________ Email Address ____________ Date of Birth ____________

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Widowed

Sex

◯ Male ◯ Female

EMERGENCY CONTACT

FULL NAME ____________ RELATIONSHIP ____________ PHONE NUMBER ____________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize East Side Chiropractic Center and any member of its staff to call, leave voice mail messages and/or email messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedure results, appointment reminders, or any other PHI related to my treatment to the following numbers

Home____________ Cell____________ Work____________ Fax____________

Email ____________

I authorize East Side Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals

Name____________ Relationship ____________ Phone#____________

Name____________ Relationship ____________ Phone#____________

Name____________ Relationship ____________ Phone#____________

Though I am seeking care from East Side Chiropractic Center, the treatment is not due to a work-related injury, automobile accident, or slip and fall. Please Initial ______________

INSURANCE AUTHORIZATION

I hereby authorize payment of benefits due to me from my insurance company, if any, to be made directly to East Side Chiropractic Center. I further authorize the release of any medical records requested by my insurance carrier. I fully understand that I am financially responsible for any charges covered by this authorization to East Side Chiropractic Center. In the event, that it becomes necessary to institute litigation over the non-payment of our fees, the cost and legal expenses incurred therein are that of the patient.

INSURANCE CERTIFICATION

This is to certify that I have I have presented any, and all information regarding my health insurance plan.

The only health insurance policy in effect is:

Name of Insurance Co.______________________ ID#______________________ Group#______________

Name of Insured______________________________ Relationship to Insured______________________________

My signature certifies that the information I have completed is accurate, and that I am not seeking care due to an Auto accident, work injury or slip and fall, nor do I have any open or pending cases.

Patient Name______________________ Patient Signature ____________________Date ______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I Acknowledge that I have received HAVE RECEIVED A COPY OF East Side Chiropractic Center's Notice of Patient Privacy Practices

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatment and other chiropractic medical procedures, including various forms of physical therapy and diagnostic x-rays by East Side Chiropractic Center. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapist, who now or in the future are employed by, or are associated with this office.

I certify that I have had the opportunity to discuss with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Furthermore, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic care there are some risks to treatment including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the coarse of care, based on the facts known at this time and in my best interest.

My signature below certifies that I have read or have had read to me that above consent. I also certify that I have had the opportunity to ask questions and options of care have been explained to me. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Name__________________________ Signature __________________________ Date______________

Massage and Manual Therapy Policy

We offer massage and manual therapy in our office as an extra service to our patients. We believe that massage and manual therapy has a value of helping you heal. Our policy is that appointments be pre-scheduled. If you must reschedule or miss an appointment YOU MUST CALL US 24 HOURS IN ADVANCE. If you do not call, there is a $25 charge. The only exception to this is if you have a serious emergency. Thank you for your cooperation.

Patient Name __________________________ Signature__________________________ Date ______________

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name ______________________ **Date** ______________

1. When did your symptoms start: ______________ **Describe your symptoms and how they began:**

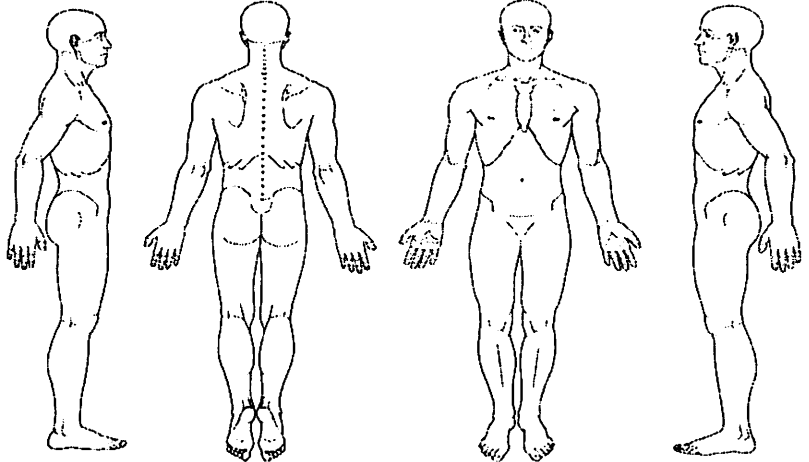
____

____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse: ______________

8. What activities make your symptoms better: ______________

9. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? ______________

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* ________ ☐ CT Scan *date:* ________
☐ MRI *date:* ________ ☐ Other *date:* ________

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation?

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

Patient Signature ______________________ **Date** ______________

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name ______________________ *Date* ______________

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐ Feet ☐ Inches Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

Past	Present	Condition
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

Past	Present	Condition
☐	☐	
☐	☐	
☐	☐	

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ *Date* ______________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ *Date* ______________